STATE OF VERMONT
DEPARTMENT OF LABOR & INDUSTRY
WORKERS COMPENSATION DIVISION
5 GREEN MOUNTAIN DRIVE, PO BOX 488
MONTPELIER, VT 05601-0488
(802) 828-2286

www.labor.vermont.gov

Form 25M **Rev 8/07**

State File No.: _____

Insurance Co. File No.: _____

Date of Injury: _____

This form shall be filed whenever a claimant is eligible to receive more than 90 calendar days of continuous temporary total disability benefits (see Rule 53.1100). Failure to file this form promptly and accurately may result in administrative sanctions pursuant to Rule 45.000.

MEMORANDUM OF PAYMENT

Employee

Last Name: _____ First Name: _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Number _____

Employer

Employer Name _____ Employer Telephone Number _____

Insurer _____

Payment Made

Weekly Compensation

Date Disability Payment Began: _____ Weekly Amount Paid: _____

Total Amount of Indemnity Paid To Date: _____

Other: (Please Explain) _____

ISSUED BY:

Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No. _____

Adjuster Signature: _____ Adjuster's Employer: _____

Adjuster License #: _____

Company Responsible for Payment: _____

Mailing Address _____ City _____ State _____ Zip _____